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ABSTRACT

This article offers the opinion that school mental health services should be built around the question: "What useful roles can schools play as part of a concerted social effort targeted to the enhancement of children's wellness?" The article suggests that there are many important roles: practical, repair-oriented roles, and new roles including engineering health-proofing school and class environments, building proactive health-facilitating curricula, and developing fluid systems of outreach to families and community settings in the service of enhancing children's early wellness. The chapter then describes the Primary Mental Health Project (PMHP), a program for early detection and prevention of children's school adjustment problems, including its accomplishments and limitations. Four prevention focal points of the program are noted: (1) focus on primary graders before problems take root and fan out; (2) systematic use of screening and early detection procedures; (3) use of carefully selected child associates as the program's prime, direct help-agents; and (4) modification of professional roles to feature systematic early screening to identify children at risk. The chapter makes two recommendations for the future: (1) greater proportions of the total school mental health effort must be invested in proactive activities; and (2) modifications must be made in the preparation and training of school and other mental health professionals. Contains over 80 references. (SD)

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• *CHAPTER 4* •

Schools and the Enhancement of Children's Wellness: Some Opportunities and Some Limiting Factors

EMORY L. COWEN

This chapter starts with a preamble that lightly sketches its ultimate direction. Its main corpus describes the thinking and experiences behind that sense of direction, and it develops further the vision to which they lead.

School psychology, school social work, and school mental health are generic, field-designating terms used to describe the work that school-based professionals do in seeking to ameliorate or contain children's school adjustment problems. These activities are shaped by a regnant world-view of what school professional roles are about and the educational and training experiences that subserve that view. Should a field's guiding objectives be recast, associated professional training must also change; that is, new roles and activities that vivify the shift must be articulated.

The school helping professions first came into being a century ago. At that time their prime goals were to identify (diagnose) blatant problems children were experiencing and deal with them as best they could. Although that guiding mandate has remained largely constant over the years, the technology used to carry it out has become far more sophisticated.

Understandably, school mental health has always mirrored the objectives and practices of the broader mental health field of which

it is part. It still does. One noteworthy recent trend in these fields is a growing interest in before-the-fact prevention (Cowen, 1994, 1996; Durlak & Wells, 1997; Mrazek & Haggerty, 1994). When prevention is the goal, malleable young children become ideal targets and schools ideal settings for such work (Cowen et al., 1996; Durlak, 1995).

The point to highlight, however, is that different views of school mental health's basic goals (e.g., repair vs. wellness enhancement) produce different scenarios for allocating professional time and implicate qualitatively different roles and activities. To the extent that building wellness from the start is viewed as a legitimate, high-priority goal, professional activities in schools must move beyond diagnosing and repairing things that have already gone wrong, indeed even beyond ontogenetically early secondary prevention, toward innovative, proactive contributions that schools are in an especially good position to make as part of a broader societal quest to enhance wellness. Children are important people and schools have important (but not exclusive) roles to play both in their early formation and in continuing steps dedicated to enhancing their wellness.

Implicit in the preceding statement is the conviction that the underlying goals and objectives (e.g., enhancing wellness vs. preventing further failure in the already failing, vs. early repair of incipient dysfunction), *not* simply location (i.e., schools vs. other places), must crucially shape professional roles and activities in *all* settings, including schools. To think of fields such as school psychology and school social work without embeddedness in a guiding context of such objectives is to put the cart before the horse. Hence a core premise of this chapter is that we stand to profit from a conception of school mental health services built around thoughtful answers to the question: "What useful roles can schools play as part of a concerted social effort targeted to the enhancement of children's wellness?" Answers to that question can help to crystallize recommendations for *Healthy People 2010*.

A brief, way-station answer to be fleshed out in the body of the chapter, is: "many important roles," including, no doubt, some that entail practical, repair-oriented steps. The latter, however, should comprise but one element in a broader matrix of wellness enhancement efforts—an element that will need to unfold in concert with other steps within a framework of reallocated priorities. New roles

that are likely to become more salient as wellness enhancement objectives achieve greater visibility include engineering health-promoting school and class environments, building proactive health-facilitating curricula, and developing fluid outreach systems to families and community settings in the service of enhancing children's early wellness.

Four Decades of Formation: The PMHP Experience

Over the past 40 years, the bulk of my professional efforts have been invested in developing, implementing, evaluating, and disseminating school-based prevention programs for young children. The sections that follow describe the school mental health issues our work has addressed and the program models we have developed and applied in this context. Finally, learnings from these experiences are used to formulate guidelines and suggestions for (school) mental health programming in the early 21st century.

Much of what we have done and learned in the school mental health arena in the past four decades is built around a master entity called the Primary Mental Health Project (PMHP), a program for early detection and prevention of young children's school adjustment problems. PMHP's early development (i.e., its first 15 years) was described in a book by Cowen et al. (1975); its subsequent growth and evolution are described in a new volume (Cowen et al., 1996). The existence of those two volumes obviates the need for detailed accounts of PMHP's rationale, course of emergence, and accomplishments. Here we provide only a bare-bones summary of that information, enough, it is hoped, to establish a foundation for several conclusions and recommendations for the future.

PMHP began in 1957 as a small pilot-experimental project, fueled both by observations about children in schools and concerns about the predominant thrust and insufficiencies of existing mental health approaches. The hows and whys of PMHP's emergence cannot be understood independent of those concerns. As prestigious review bodies of the time (Joint Commission on Mental Illness and Health, 1961) pointed out, the mental health fields were then beset by vexing problems, including (a) shortages of professional personpower; (b) uneven distribution of resources that

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sharply limited access of underserved groups such as poor people and children to the system's scarce and costly services; and, perhaps deadliest of all, (c) the fact that the system's limited resources were targeted primarily to people with already rooted, often refractory, problems—precisely those with the poorest prognoses. Under the latter conditions, even the most effectively delivered restorative services have limited potential.

These vexing problems formed the backdrop that shaped PMHP's early development (Cowen et al., 1996). In contrast with the conceptualizations and practices that guided the then-dominant mental health delivery system, the initial PMHP and its later programmatic extensions were carved out in the image of three masters: *prevention,* rather than repair, as the overarching goal; *young children,* rather than adults, as prime targets; and *schools,* because they offered systematic access to young children, as the prime locus.

At its core, PMHP is built on four structural pillars: (a) a focus on primary graders before problems root and fan out; (b) systematic use of screening and early detection procedures to identify at-risk young children as soon as possible; (c) using carefully selected, trained, supervised nonprofessional child associates as the program's prime, direct help-agents with these early identified children; and (d) modifying professional roles to feature systematic early screening to identify children at risk; selection, training, and supervision of child associates; and consultative roles with teachers and other school personnel. The basic goals of this revamped delivery system are to bring prompt preventively oriented help to young children when it can do the most good, and to extend the reach of effective early services to children in need.

PMHP works as follows: Brief, objective screening measures that we have developed are used to profile children's school-related problems and competencies (see, e.g., Hightower et al., 1987; Hightower et al., 1986). Information derived from those measures, along with feedback from teachers and parents, is reviewed at an initial assignment conference early in the school year. If significant indicators of ineffective functioning (e.g., acting-out, shy-anxious, or learning problems) are identified, children are referred to PMHP and intervention goals are established. After parent permission has been received, child associates begin to see referred children regularly—most individually, but some in small groups. Associates

are selected for their human qualities (e.g., warmth, caring for children) rather than prior education and training. They receive some training before they start, further on-the-job training and supervision, and later specialty training to broaden their skills. Half-time associates, working under professional supervision, can see roughly 12-15 children a week.

A typical school-based PMHP team includes project professionals, child associates, primary grade teachers, and a school administrator. After the initial assignment conference, team members continue to exchange pertinent information and coordinate goals on the child's behalf. Midyear progress conferences are held to review each child's current situation and, when needed, to realign goals and approaches. End-of-year conferences evaluate children's overall progress in PMHP and, if needed, formulate plans for further helping steps. Program consultants provide support, stimulation, and inputs regarding especially challenging children and troublesome issues.

PMHP is built on meaningful interfaces between service and research. Many of its studies are addressed to concrete program issues and many of its research findings are fed back to strengthen program services. Several program developments that extend PMHP's reach, or strengthen its applicability to particular children, have evolved over the years as a product of this service-research marriage. Those include mini-programs for (a) seeing children in small groups; (b) bridging between schools and families (i.e., "parent" associates); (c) using limit-setting approaches with acting-out children; (d) crisis intervention; and (e) planned short-term intervention. These "add-on" programs come about in much the same way structurally. First, the need for a program is identified and a pilot program to meet that need is developed and explored. Promising pilot models are evaluated more extensively and, when found to be effective, they are incorporated into PMHP's mainstream through program-relevant training for child associates. In the aggregate, these new options have added considerably to PMHP's flexibility and reach (Cowen et al., 1996).

Research has been central to PMHP since Day 1. Research studies have explored diverse program-related matters, including (a) child and family variables associated with children's school adjustment; (b) attributes of effective child associates; (c) the nature of the associate-child interaction process in PMHP; (d) children with

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whom the program is more, versus less, effective; and (e) the efficacy of new program offshoots. Cowen et al.'s (1996) review of PMHP's research noted that outcome studies have been the most extensive aspect of this work. Spanning nearly 40 years, such studies have evaluated PMHP's efficacy in a broad range of settings and with diverse populations. Several of these studies have been truly massive, including one documenting program efficacy based on 47,000 children seen through PMHP in some 200 California school districts, over a 5-year period (Cowen et al., 1996).

Among the key conclusions from these many program evaluation studies are the following: (a) Overall, PMHP effectively strengthens the behavioral adaptation and school performance of young, at-risk children; (b) initial short-term program gains endure over time; (c) because the approach works well with children reflecting diverse sociocultural backgrounds, it is a good way to reach underserved populations; and (d) PMHP is cost-effective compared to other forms of intervention with children.

In its first two decades, PMHP laid the basic program model in place, fine-tuned and extended it, and developed a sound empirical base documenting its efficacy. After those early credentializing steps were completed (Cowen et al., 1975), more effort was invested in two other types of activities, that is, program dissemination and new primary prevention programming. Again, because the recent PMHP volume (Cowen et al., 1996) details both these developments, they are described only briefly here.

A next natural question, following documentation of PMHP's efficacy, was how this hard-come-by knowledge could best be applied to extend program benefits to many more children in need around the country. This challenge stimulated a set of dissemination activities that PMHP has pursued for two decades. These include (a) conducting national workshops to elevate consciousness about the program, (b) doing consultative visits to implementing districts and providing short-term internships for their personnel in PMHP demonstration schools, (c) establishing regional PMHP demonstration centers each based on its own successful program, and (d) working with state offices to promote within-state program dissemination.

The last of these steps led to the passage of specific PMHP enabling legislation, with supporting budget, in four states (New York, California, Washington, and Connecticut), and to extensive

but less formal program development in other states (and countries). As a result of these dissemination activities, PMHP programs are now operating in more than 700 school districts in this country and elsewhere (e.g., Australia, Canada, Israel). These programs serve sociodemographically diverse children and range from stress-ridden, inner-city settings (Meller, Laboy, Rothwax, Fritton, & Mangual, 1994) to new consortia of 4-6 underresourced rural school districts that share program services (Farie, Cowen, & Smith, 1986). As such, they illustrate an appealing feature of the PMHP model, that is, its potential adaptability across diverse settings and circumstances, including programs for historically neglected populations.

Collectively, this family of PMHP programs now brings early, effective, preventively oriented help to many thousands of young schoolchildren at risk annually. This development has helped to modify how school mental health services are conceptualized and delivered and, in that sense, has contributed to the elusive goal of bringing about constructive social change.

PMHP's early development demonstrated that the program model made good sense both as a concept and empirically in relation to traditional, after-the-fact, repair-oriented school mental health approaches. Although we saw this as a significant forward stride in effective, ontogenetically early secondary prevention, two realities raised cautions in our minds: (a) Because PMHP was directed primarily to children in whom warning signs had already been detected, it remained a somewhat reactive program, rather than one that served all children in health-enhancing ways; and (b) even though PMHP was effective overall, some children were not helped by it.

As these awarenesses grew, a more basic challenge began to crystallize: "What could schools do to optimize the wellness and school adaptation of *all* children from the start, beyond targeting programs to the identifiable fraction at risk?" That question highlights one key goal of primary prevention, a generic name for a family of programs that seeks to enhance wellness as well as to avert psychological difficulties (Cowen, 1994, 1996; Durlak, 1995; Durlak & Wells, 1997). Thus, we have also sought, in the past 20 years, to develop primary prevention program models that broaden PMHP's scope by reaching children more proactively. The approaches we have explored reflect three strategies: (a) teaching

children adjustment-enhancing skills and competencies, (b) modifying class environments and practices to improve educational and behavioral outcomes, and (c) developing programs that teach adaptive coping skills to children at risk by virtue of exposure to significant life stress.

Four such developments are described briefly here—two class-based, for all children, and two non-class based, targeted to youngsters with specific risk histories. One set, that is, competence training programs (Gesten, Flores de Apodaca, Rains, Weissberg, & Cowen, 1979; Gesten et al., 1982; Spivack, Platt, & Shure, 1976; Spivack & Shure, 1974), seeks to train in interpersonal, or social, problem solving skills (e.g., recognizing feelings in self and others, generating alternative solutions to interpersonal problems, evaluating the consequences of solutions, and taking the role of the other) and self-control or adaptive assertiveness skills (Rotheram, Armstrong, & Booraem, 1982) known to relate to good adjustment. The goal of such skill training is to enhance children's adjustment and school adaptation.

Another of our primary prevention steps was to develop programs built around planful change in class environments. One such approach, called the "jigsaw" classroom (Aronson, Blaney, Stephan, Sikes, & Snapp, 1978), rests on the assumption that perceived class attributes such as order and organization, affiliation, and involvement promote positive student outcomes (Moos, 1979). Jigsaw classrooms use structures and practices designed to enhance such perceptions. Specifically within PMHP, Wright and Cowen (1985) developed a jigsaw program based on mixed gender and ability-level groups of five children in fifth-grade social studies classes. Each group member had to learn one segment of a larger curriculum unit and teach it to groupmates. This approach was found to be effective in terms of both academic and interpersonal outcomes. A related, later PMHP-developed program called Study-Buddy (Hightower, Avery, & Levinson, 1988) pairs students, who work together in dyads three to five times a week over the school year, to promote reciprocal peer learning and cooperative peer relationships (Cowen et al., 1996).

Two other of our primary prevention programs are targeted to children at risk. The first, the Children of Divorce Intervention Program (CODIP), was the product of two convergent strands: (a) sharply rising divorce rates and referral rates of children of divorce

to PMHP; and (b) observational and empirical data documenting the negative effects of divorce on children's adjustment and school performance. To date, six versions of CODIP have been developed for urban and suburban, kindergarten to eighth-grade children. Although these programs share common objectives, their technology varies as a function of the age and sociodemographic attributes of the target populations. As minimal common denominators, however, all CODIP programs provide support; teach appropriate ways to identify and express feelings; clarify divorce-related misconceptions; teach problem solving, communication, and anger control skills; and enhance children's perceptions of self and family. Research findings document CODIP's adjustment-enhancing effects for diverse groups (Pedro-Carroll & Alpert-Gillis, in press; Pedro-Carroll, Alpert-Gillis, & Cowen, 1992; Pedro-Carroll & Cowen, 1985; Pedro-Carroll, Cowen, Hightower, & Guare, 1986).

A final primary prevention probe, called the Rochester Child Resilience Project (RCRP), is still evolving. Targeted to young profoundly stressed urban children, the RCRP has identified child variables (e.g., perceived self-worth, social problem solving skills, empathy, realistic control attributions), through testing, and developmental and family milieu variables (e.g., easy early temperament; a warm, caring child-parent relationship; father involvement in child care; and sound, authoritative discipline practices), through in-depth interviews with parents, that correctly classified 85% of these highly stressed youngsters as having stress-resilient or stress-affected adjustment outcomes (Cowen et al., 1992; Hoyt-Meyers et al., 1995; Wyman et al., in press; Wyman, Cowen, Work, & Parker, 1991; Wyman et al., 1992). These findings offer a base on which to develop preventive interventions for children at risk for unfortunate personal and academic outcomes because of chronic exposure to major life stress. We have begun to develop a program model for preventive intervention with such youngsters (Cowen, Wyman, Work, & Iker, 1994).

Although program manuals have been developed for each of these new primary prevention projects, as a group they are less extensively explored, or evaluated, than PMHP. Even so, their emergence has modified PMHP's focus and resource allocations. Whereas, initially, 100% of our efforts were invested in the basic PMHP model, about 50% of our resources are now allocated to "vintage" PMHP, and 25% each to program dissemination and new

primary prevention program initiatives. More important, the field at large has undertaken increasingly serious exploration of wellness-oriented, primary prevention program options that go far beyond our own limited probes. The latter wholesome development is considered later in the chapter.

The PMHP Experience: Accomplishments and Limitations

The preceding section described PMHP. Backing off from those trees to glimpse a larger forest, the last half of the chapter overviews accomplishments and limitations of the PMHP development and uses that analysis as a base for considering (a) the future place of ontogenetically early secondary prevention programs in schools; and (b) needed types of complementary programs.

The PMHP development has been exciting and socially contributory. Its special blend of components offers a cohesive package that provides early, effective, preventively oriented services to many more children than traditional school mental services can reach. Focusing such services on primary graders holds potential for reducing the flow of later, more serious school- and life-adjustment problems. Moreover, because PMHP has been shown to be effective with diverse groups, it can be targeted specifically to underserved populations in which the need for services is strong. Schools find PMHP to "make sense," that is, it well addresses many vexing, everyday problems they experience. Consumer satisfaction with the program, its extensive documentation, and its flexible application potential are all big pluses for dissemination. Also, the productive marriage between service and research in PMHP has made it an ever-evolving, ever-improving program that continues to reach more children effectively.

The preceding accomplishments are substantial. They suggest that the PMHP model that has evolved offers a balanced set of early preventive options that merit consideration as one key element in a multifaceted plan for future school mental health services. Although such a component is needed, it will not fully address all the child learning and adjustment problems that many schools are called on to engage daily. The demurrer in the last sentence leads to a consideration of things PMHP has *not* done so well, and

educated guesses about *why* not. Such an analysis is motivated neither by modesty nor self-derogation; rather, it is a needed, reality-based step in developing recipes for future school mental health services.

PMHP's most obvious limitation is that it does not work well for *some* children. Although it is hard to attach exact numbers to the term "work well," a recent, 5-year program outcome study involving 47,000 children from several hundred California school districts suggests that 65% of PMHP-seen children do very well, 20% show modest gains, and the remaining 15% gain little or not at all (Cowen et al., 1996). Those numbers describe only how children looked when the intervention ended and say nothing about the durability of those early outcomes. But even within a short-term framework, they make it clear that PMHP does not always work.

There are several reasons why PMHP is not effective for all children. First, even though its innovative child associate approach is sensible and effective overall, not all associates are equally effective, and not all associate-child pairings are made in heaven. In practice, some fraction of those pairings range from poor to marginal. This is less an intrinsic flaw in the program model and more a failing in the mechanics of its execution.

Other less than satisfactory PMHP outcomes come from misapplications of the approach. PMHP was never intended to be all things for all children. It was designed as an early preventive intervention, not as a restorative program for children with deeply rooted, pervasive problems (e.g., profound conduct disorder; major childhood depression). Nevertheless, in some settings, children with long-standing, serious problems *do* enter the program for any of several reasons. The latter include (a) pressures from teachers to do something about "difficult" children (e.g., chronic acter-outers), even if it is just to get them out of the classroom for brief respites; (b) professionals sometimes endow PMHP with an (unwarranted) infallibility and agree to see children whose problems are serious enough to overtax the best of what it can offer; and (c) in some communities that lack mental health facilities, because PMHP is the "only show in town," children are either seen within its auspices or not at all. Because PMHP is not an approach of choice in the preceding situations, it may at best be minimally effective with children who fail into those categories. These situations, too, less

reflect a shortcoming in the program model and more an overextension in its application.

With regard to limitations of applicability that we have identified, PMHP has sought, from the start, to develop correctives to extend the program's reach and improve its batting average. Some of those efforts have been very effective, others less so. Examples of successful extensions include offshoot programs for small group intervention (Terrell, McWilliams, & Cowen, 1972), work with acting-out children (Cowen, Orgel, Gesten, & Wilson, 1979), and planned short-term interventions (Winer-Elkin, Weissberg, & Cowen, 1988) that have enhanced PMHP's reach and versatility.

Early experience with PMHP also made it clear that however effective this early secondary prevention model was with the children it reached, it was still reactive, reaching only some children showing early risk signs, and was less than 100% successful. This realization fueled exploration of primary prevention approaches designed to enhance the wellness of all children, in the belief that such proactive steps are much needed and will become an increasingly important aspect of future mental health programming in schools.

The steps we have thus far taken in this direction are more exploratory and paradigmatic than comprehensive and definitive. Collectively, they comprise only a tiny fraction of a rising tide, involving many groups and approaches seeking to develop mass-oriented, proactive program models that differ qualitatively from past restorative approaches. Several recent sources provide rationales for these largely school-based primary prevention programs and cite promising examples (Consortium on the School-Based Promotion of Social Competence, 1994; Cowen, 1994, 1996; Durlak, 1995; Elias & Tobias, 1995; Lorion, 1990; Price, Cowen, Lorion, & Ramos-McKay, 1988). Discussion of this development here is limited to several outstanding illustrations of the approach, primarily to concretize what has thus far been said abstractly. Weissberg and Greenberg's (1997) recent scholarly, thought-provoking review of this area offers a much richer consideration of the topic and describes a number of effective wellness-oriented programs (primarily school-based) for children and youth ages 0-18. Their review is "must-reading" for those with interest in the current status, and promise, of a competence enhancement approach.

The development of interpersonal problem solving training programs for children (Spivack et al., 1976; Spivack & Shure, 1974) is an early competence-building approach that has had substantial enduring value. This work rests on a generative knowledge base showing that maladapted groups are deficient in such social problem solving (SPS) skills as generating alternative solutions and evaluating their consequences. Hence curricula were developed to train young children in these skills. The heuristic value of this work stemmed both from early findings and, importantly, from the fact that it modeled an appealing new health-building paradigm. SPS training, in which we too were involved (Gesten et al., 1979; Gesten et al., 1982; Weissberg, Gesten, Carnrike, et al., 1981; Weissberg, Gesten, Liebenstein, Schmid, & Hutton, 1980; Weissberg, Gesten, Rapkin, et al., 1981), has continued over the years both in the form of freestanding programs and condensed modules that are elements in expanded social competence training programs (Durlak, 1995; Elias & Clabby, 1992; Elias & Tobias, 1995).

As several limiting realities of the initial SPS approach became clear, work in this area went through some metamorphoses (Consortium on the School-Based Promotion of Social Competence, 1994; Weissberg & Elias, 1993). One such reality was that encapsulated (one-shot) SPS programs were found to have restricted initial value and limited staying power (Durlak, 1983). Also, evolving generative knowledge bases identified relationships between other (non-SPS) families of variables (e.g., impulse control, empathy, communication and stress management skills) and positive adjustment outcomes. These realities led to the development of second-generation social competence training programs, in which SPS training was but one element in more sophisticated, comprehensive curricula that (a) extended over multiple years, (b) introduced new competencies at developmentally appropriate times, (c) included boosters for skills previously taught at simpler levels, and (d) created class and school mechanisms to promote real-life application of program learnings after the formal program ended.

There now exist multiple examples of effective social competence training programs of this type. These programs have yielded such positive outcomes as enhanced self-control; problem-solving, decision-making, and conflict resolution skills; and lowered

anxiety and susceptibility to alcohol and substance use (see, e.g., Caplan et al., 1992; Cowen, 1994; Elias, Gara, Schuyler, Branden-Muller, & Sayette, 1991). Their success in terms of both proximal and longer-term, bellwether outcomes has stimulated exploration of third-generation social competence training programs that are continuous from kindergarten to 12th grade, introducing new components as children's interests and cognitive capabilities mature (Consortium on the School-Based Promotion of Social Competence, 1994; Weissberg & Elias, 1993; Weissberg & Greenberg, 1997). These programs seek to promote a full spectrum of core social competencies known to undergird wholesome adjustment in children.

The Child Development Project (CDP) is a different, systemic approach to enhancing children's wellness. CDP seeks to modify the total school environment in wellness-enhancing ways (Battistich, Solomon, Watson, Solomon, & Schaps, 1989; Developmental Studies Center, 1994; Solomon, Watson, Delucchi, Schaps, & Battistich, 1988). With coordinated inputs from schools, families, and children, CDP strives, at its core, to create a "caring school environment," from kindergarten through sixth grade, in ways that build on children's prime motivational needs for autonomy, belongingness, and competence (Deci & Ryan, 1985). To promote autonomy support, CDP uses a schoolwide discipline approach in which children are responsible for setting and upholding class rules. This is intended both to empower them and to foster democratic values. Children's sense of belongingness is promoted by using cooperative learning formats at all grade levels and a buddy program that pairs older and younger children. Reading and instructional materials are selected to help children better understand themselves and others and to promote prosocial values. CDP rests on the assumption that children will engage better in, and profit more from, the school experience if it is intrinsically interesting and if they have genuine shaping inputs in what they do.

Empirical findings support that assumption. Classroom observations showed that the program was implemented as intended. Thus, program classes at all grade levels exceeded comparison classes in terms of judged warmth and supportiveness, mutual help activities and cooperative work formats, emphasis on interpersonal understanding and personal values, opportunities for student autonomy, and discipline formats that promoted responsible behavior.

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In terms of program outcomes, CDP children were found to be more cooperative and considerate than controls, better able to express their views and resolve conflicts, and more willing to include peers in group decision-making steps. They exceeded controls in self-esteem, empathy, and, importantly, perceived sense of community. They had more friends, felt better accepted by peers and more competent socially, had less anxiety, and evidenced a better understanding of others. Their academic performance was at least as good as comparison children's—better in some areas (e.g., reading comprehension).

Follow-up, 3 years later, when participants were seventh and eighth graders in new schools, showed that early program gains were maintained and that there were important new benefits such as lower rates of alcohol and marijuana use and fewer delinquent or violent behaviors (Battistich, Schaps, Watson, & Solomon, 1995). Schools highest in fidelity of program implementation had the best outcomes. Significant program gains were also found in schools with high proportions of poverty-level students. A variable that favored positive program outcomes, and overrode the typical negative effects of poverty, was student perception of the school as a caring community (Battistich, Solomon, Kim, Watson, & Schaps, 1995). CDP's initial demonstrations of significant program benefit are now being replicated around the country.

Both second-generation social competence training and CDP's social system modification programs are promising approaches that (a) are integrated naturally into a school's way of operating, (b) reach all children in a school building, (c) extend over multiple school years, and (d) share the prime goal of enhancing children's wellness. Such population-oriented wellness programs, relatively new to the school scene, rest on ways of thinking, targetings, and practices that differ qualitatively from the past repair-dominated approaches in school mental health. It is hoped that this new thrust will be a significant aspect of future school mental health programming, with concomitant modifications in the training of school mental health professionals.

Although the wellness enhancement programs described seem timely and promising, even the best and most comprehensive of them may be too little and too late for increasing numbers of children whose formation and early life experiences so markedly shape the outlook and problems they bring to school, that the

school's mission may, de facto, be defeated before it starts. These are the children who grow up in the shadow of profound, chronic stressors (e.g., neighborhood crime and violence; family chaos and disorganization; exposure to substance abuse, poverty, and squalid living conditions) that exact staggering tolls. Increasingly, educators see these youngsters as prime candidates for school failure and its many unfortunate associated life sequelae if poor starts are not reversed by third grade. Given the severity of their problems and life situations, there is little reason to expect that 20 meetings with a compassionate, caring adult, or even the best executed wellness enhancement program for that matter, should turn a bleak situation of such magnitude and chronicity around. Innovative new approaches that call for new roles and activities by schools are needed to meet this vexing and potentially destructive challenge (Carnegie Foundation Report, 1996).

Wellness Enhancement: Levels of Address

The unexplained term *wellness enhancement* is broad and projective. Like the concept of prevention, it can be viewed in ways that range, at one extreme, from trying to help the already very sick to be less sick, to promoting wellness in all people at the other. Wellness objectives can be pursued in many different ways and at different points along such a hypothetical continuum. This can be illustrated using three arbitrarily selected points.

The first level, reflecting school mental health's origins, and prime, current modus operandi, consists of efforts to diagnose and repair things that have already gone wrong. This costly, labor-intensive approach reaches only a small fraction of those in need, that is, children with the most serious, entrenched problems that resist change and have the poorest prognoses. Although such repair activities will undoubtedly remain focal in future school mental health services (whether through inertia, in response to immediate pressures, or for reasons of compassion), their payoff value, as suggested earlier, is limited. It is hoped such services will absorb only a fraction of school mental health's limited total resources, in ways that do not restrict the development and application of other promising approaches.

A second level of services, that is, systematic early detection and early secondary prevention, is well reflected in PMHP's model. Advantages of this strategy over reactive approaches targeted to already florid problems are that it reaches many more children at risk sooner, before such problems root and fan out, and can thus offer meaningful correctives earlier. Accordingly, programs such as PMHP that combine systematic early detection and prompt, effective intervention for identified children at risk should figure prominently in a balanced portfolio of future school mental health services.

Primary prevention activities represent a third set of roles for school mental health professionals that differ from the two prior ones both in intent and substance. Their prime objective is to promote wellness in all children proactively, rather than struggling reactively to minimize existing problems. This promising set of still-evolving roles is not yet either widely perceived or meaningfully incorporated into the preparation of school mental health professionals. The primary prevention or wellness enhancement programs that are currently best known to professionals are those that (a) train children in skills and competencies that promote wellness outcomes; and (b) modify class and school environments and practices with that same goal in mind. Yields from this work to date suggest that a significant shift in the school mental health activities in these directions can help many young children adapt more effectively to school, and to life.

Although the types of primary prevention programs described are surely promising "in general" (Durlak & Wells, 1997; Mrazek & Haggerty, 1994), they may be insufficient for many children in modern society whose lives before school are characterized by chronic exposure to profound stressors that exact major tolls. Such stressors can be so overwhelming and pervasive for a family that the child's educational experience pales into insignificance next to them.

This reality, viewed from a broader wellness enhancement perspective, calls for earlier, more basic steps in children's formation than the most that schools can offer after the fact. The phrase "more basic steps" is meant to include (a) social change to enhance living conditions, opportunities, and hope for many people in modern society; and (b) preceding school programs with family and community outreach programs that seek to enhance the wellness

and school preparedness of children at serious risk from the very start.

Mounting evidence of considerable importance suggests that such comprehensive early wellness enhancing steps for children and families can contribute importantly to the prevention of later costly and damaging personal and social outcomes, for example, delinquency (Tolan & Guerra, 1994; Yoshikawa, 1994, 1995; Zigler, Taussig, & Black, 1992). In this arena, it appears that sound building in the first place is much to be preferred to the best of all possible repairs. Parent education programs before the child is born (Olds, 1988); active outreaching programs for parents after the child is born (Broussard, 1989; Greenspan, 1981); and effective, comprehensive early childhood programs such as Head Start (Schweinhart, Barnes, & Weikart, 1993; Zigler, 1994; Zigler & Styfco, 1994) exemplify the types of important steps that are needed to establish wholesome early bases in the quest for wellness. Schools, particularly urban schools, must have greater future involvements in planning, conducting, and supporting programs that precede the school experience and seek to optimize the benefits that children derive from schooling.

Society's concerns about the many children who begin school unprepared, and who thus do not profit from school, has grown steadily. The unfortunate effects of such adverse starts are increasingly evident. Many escalate into major academic and behavioral problems, at great cost to the affected children, schools, and society. Schools that have been witness to these problems for many years can readily attest to their magnitude.

A point implicit in this discussion is that there are strong continuities between the nature of the child's formation and early experiences, and what happens in school (i.e., what the child can derive from the school experience). In this arena, schools cannot be islands unto themselves. Unless the chronic, overwhelming problems that many children experience before they enter school, and concurrently with their schooling, can be short-circuited and healthier starts promoted, school failure will remain a high likelihood for them.

The preceding reality has stimulated consideration of new types of school-community partnerships designed to enhance children's early adjustment and increase their preparedness for school. In this context, Dryfoos (1994) developed a sweeping proposal for "full-service schools" in communities with high proportions of multiple-

risk children. These settings would provide high-quality education for children as well as other essential services (e.g., health and social services) to families. The ultimate goal behind providing coordinated and readily accessible services in a single setting (i.e., "one-stop shopping") is to facilitate the adaptation of families and thereby establish a path toward meaningful and effective educational experiences for the child.

Others (Wang, Haertel, & Walberg, 1995) have focused on this same theme. A recent special issue of *Professional Psychology* summarized current thinking and recommendations in this area (Paavola et al., 1996; Talley & Short, 1996). In this forum, Paavola et al. (1996) formulated the underlying issue as follows: "The unmet needs of children and families have continued to grow. These conditions are particularly serious for impoverished minority populations. Support has grown for a paradigm shift for service delivery strategies, toward the use of coordinated and collaborative services . . . particularly with respect to the role of schools" (pp. 34, 39). The general approach proposed in those sources includes both school-based and school-linked services, and entails new foci and activities, including some outside the school's walls, for school mental health professionals. A note of caution, however: Neither a full-service school model nor the proposed new type of school-community partnership structures is per se sure to work. Because function is at least as important as structure, the utility of such partnerships may depend on the extent to which they focus on wellness enhancement and school preparedness, not just remediating florid problems. The Carnegie Foundation Report (1996) takes a similar position in calling for a "practical, prevention-oriented approach" that includes (a) universal access to high-quality early care and education for all 3- and 4-year-olds; (b) expansion of parent support and education programs; and, most basically, (c) a prime focus on early prevention rather than later remediation. These worthy objectives highlight wellness goals and implicate new school-community linkages and new professional roles.

On Goals and Roles

One nicety of a book titled *Healthy Children 2010* is that it encourages recommendations about future directions. On the basis of the thinking and programmatic experiences described in this

chapter, several issues touched on, but not fully developed, in the preamble can be revisited. One concerns future roles and activities for school mental health professionals.

Earlier, we sketched out three different (not mutually exclusive) levels of school mental health functions along a hypothetical wellness enhancement continuum. That analysis offers a framework, depicted skeletally in Figure 4.1, for considering both how school mental health roles have evolved, and perceived needs for future role changes. When this field first came into being, and for many years thereafter, its roles reflected only Level 1 (containment and repair) activities. Although such activities still comprise the dominant core of school mental health services, recurrent problems not solved by such an approach stimulated explorations of ontogenetically early secondary prevention and wellness-oriented primary prevention programs. Sound prototypic models for the latter approaches are now available and in growing use. As these models are fine-tuned, and clinical-observational and empirical evidence of their efficacy cumulates, such approaches will grow in number and diversity, and professional roles needed to bring them off effectively will be more fully articulated. Indeed, enough is already known about the efficacy and promise of several of these emergent approaches to warrant recommendations by *Healthy People 2010* for needed new school professional roles and changes in training to facilitate the effective conduct of those roles.

One obvious justification for moving in these directions is that the new roles offer intrinsically appealing, heuristic options. A second, less obvious but nonetheless important, one is the growing realization that enhancing children's wellness per se may be the best and most pragmatic route to preventing problems (Cowen, 1994)—a route that schools can help significantly to pave. Pursuing these evolving options calls both for primary prevention roles in the schools and new school-community partnerships designed to enhance children's early wellness and increase their school preparedness, well before the official moment of school entry.

The variables in Figure 4.1 are oversimplified and arbitrarily selected. Levels of function are less pure and less discrete than their representation, and role evolutions over time have been more complex and continuous than what is suggested by the three arbitrarily depicted cross-cuts in time. Finally, the absolute percentages of investment entered for each type of function, at each

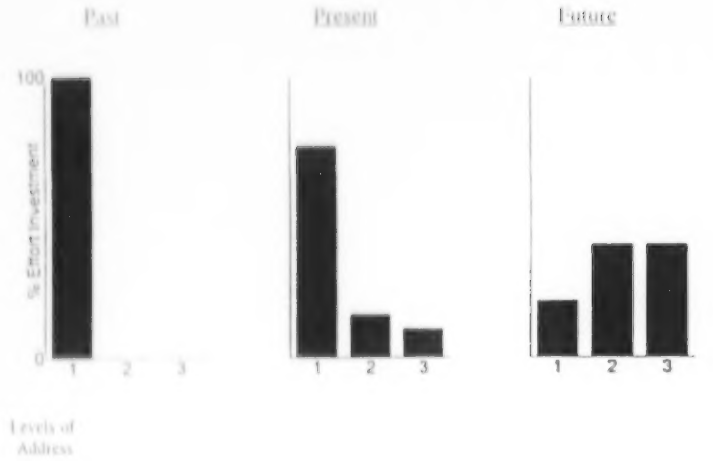

Figure 4.1. Evolution of School Mental Health Roles
NOTE: Level 1 = containment/restoration; Level 2 = early detection and ontogenetically early secondary prevention; Level 3 = primary prevention/wellness enhancement.

time-point (surely for the future), reflect lots of guesswork. Indeed, for that very reason, another useful objective for *Healthy People 2010* would be to gather information about actual, current deployments of school professionals' time across activity categories to establish a baseline for informed recommendations about needed role changes. The intent of Figure 4.1 is simply to portray broad trends, both actual and needed, in the evolution of school mental health roles.

Overview, Summary, and Next Steps

Important changes are taking place in the concepts and practices that guide the mental health fields, particularly school mental health. One is a broadening of its past dominant mandate (i.e., to repair problems), to include before-the-fact prevention—indeed, more basically the enhancement of wellness. Explorations of this broadening purview have led both to the development of sound, useful programs for systematic early detection and prevention of

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school adjustment problems, and increasingly effective steps toward developing wellness enhancement programs for all children. The latter include second-generation social competence training programs and creating proactive, wellness-targeted school environments.

Although both these developments merit strong representation in future school mental health portfolios, they are not likely to be sufficient to address the vexing school adjustment problems that stem, for some children, from profoundly difficult early life situations. For such youngsters, and they are not few in number, school mental health activities restricted by the Procrustean beds of location (i.e., in school) and addressable issues (i.e., doing the best that can be done for a child with already pervasive problems) are likely to remain limited in value. Rather, the pervasiveness and devastating effects of the problems described suggest a strong need for structures and programs designed to enhance children's wellness and readiness from the start. Such a shift in orientation necessarily implicates new types of community outreaches and interfaces for schools, new alliances with other agencies, and direct involvements in programs that will help children to profit from school. For many children, societal wellness enhancement strategies must begin at birth or before, and continue actively in the early childhood period to optimize formation of solid foundations and the skills and attitudes needed for meaningful gain to accrue from the school experience.

Schools will continue to play a vital role in children's formation and in the maintenance and the enhancement of their wellness. To deliver effectively on that promise, however, calls for programs and activities that differ qualitatively from what has traditionally comprised the defining corpus of school mental health. For notions of prevention and wellness enhancement to take hold in the next century, substantially greater proportions of the total school mental health effort must be invested in proactive activities that strive to enhance wellness outcomes. Such a changing focus will require cognate modifications in the preparation and training of school, and other, mental health professionals. To the extent that high priority is accorded to the goal of enhancing children's wellness, the objectives suggested in the two preceding sentences offer a mini-framework within which *Healthy People 2010* can formulate needed future recommendations.

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